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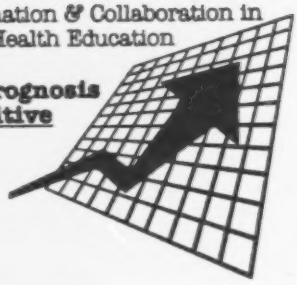
Proceedings and Findings:
THE STATEWIDE CONFERENCE OF THE FLORIDA ALLIED HEALTH ARTICULATION PROJECT.

June 21, 1989 • Orlando, Florida

Coordination & Collaboration in Allied Health Education

The Prognosis is Positive



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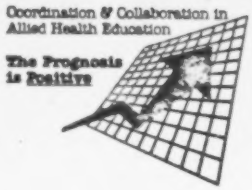

Allied Health Education:
Communication, Coordination and Collaboration

Statewide Conference of

THE FLORIDA ALLIED HEALTH ARTICULATION PROJECT, PHASE I

June 21, 1989 • Orlando, Florida

Sponsored by The Florida Department of Education in conjunction with Tallahassee Community College and Valencia Community College

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Introduction:

"THE TIME IS CRITICAL FOR A FOCUS ON ALLIED HEALTH EDUCATION."

Recommendations for improved coordination and collaboration have provided a common theme across recent reports on allied health education in Florida. The recommendations have covered a wide range of issues related to coordination in allied health education, including the coordination, or articulation, of allied health education programs to facilitate students' transfer from one program to another. Calls for increased coordination in assessing and planning for the state's allied health manpower needs have also been highlighted.

The time is critical for a focus on allied health education. Escalating costs in both health care education and service delivery have fueled concerns about efficiency in preparing allied health personnel. Florida's population growth, our large proportion of elderly residents, shifts in our workforce demographics, and the "restructuring" of health care services have magnified concerns about allied health manpower shortages. More accurate, shared information describing the state's health care labor market is required if we are to make sound educational planning decisions which fit the needs of the health care system. Articulation of educational programs – and the career mobility this supports – are required to achieve the cost-efficiency we seek, as well as to encourage veteran allied health workers to remain in the field.

This past year, the Commissioner of Education's Articulation Coordinating Committee officially adopted the goal of promoting the articulation of allied health programs within Florida. To accomplish this goal, the Committee launched the Florida Allied Health Articulation Project – a project funded through a grant from the State Board of Community Colleges to Tallahassee Community College, and carried out in conjunction with a statewide task force of allied health educators and policy makers.

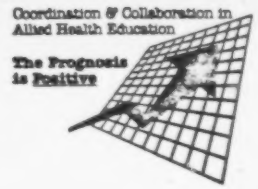
Members of the Allied Health Articulation Task Force have worked since March, 1989, to identify strategies for building a more fully articulated allied health education system, including a coordinated system of manpower data collection. The conference, ALLIED HEALTH EDUCATION: COMMUNICATION, COORDINATION AND COLLABORATION, provided an opportunity for the Task Force to share the findings and recommendations from its first phase of work with individuals from all segments of the educational, governmental and health care communities. Most importantly, it provided an opportunity to draw upon the expertise of conference participants to target the specific activities that should be undertaken as next steps in the Florida Allied Health Articulation Project.

This booklet presents highlights from the conference proceedings. These include keynote addresses, an overview of Task Force findings and recommendations and a commentary on project activities to date. Taken together, the proceedings document the broad issues that have focused concern on allied health articulation. They also describe the framework of guidelines and strategies within which future work on enhancing allied health articulation will take place.

The initiation of the Florida Allied Health Articulation Project is an important transition. It marks a state-level eagerness to move beyond written reports and recommendations to begin the actual work of articulating our allied health education and service systems. We look forward to both the collective challenges and the collective rewards this work will bring.

"MEMBERS OF THE ALLIED HEALTH ARTICULATION TASK FORCE HAVE WORKED SINCE MARCH, 1989, TO IDENTIFY STRATEGIES FOR BUILDING A MORE FULLY ARTICULATED ALLIED HEALTH EDUCATION SYSTEM."

Opposite: The conference opened with introductory remarks by Richard Gutekunst, Dean of the College of Health Related Professions at the University of Florida and chair of the Allied Health Articulation Task Force.



Welcome and Program Overview:

"...A WAY TO ACT NOW TO AVERT POSSIBLE DISASTER."

Speech by Assistant Education Commissioner Laurey Stryker

Thank you, Dr. Gutekunst, for that kind introduction. I'm happy to be here today, and happy to see so many representatives from so many areas of our state here at this conference. I see people from state government, like HRS and the legislature. And, of course, there are representatives from many of Florida's finest education institutions with us today.

And while I'm on the subject of education institutions – I'd like to thank Tallahassee Community College for helping us to sponsor this event and Valencia Community College for acting not only as a sponsor for this conference, but also as our host. You have a lovely campus. Thank you for sharing with us today.

"THE FUTURE PRESENTS US WITH MANY PROBLEMS AND CHALLENGES, BUT MANY OF THE ANSWERS WE WILL NEED ARE ALREADY WITHIN OUR GRASP."

Opposite: *Laurey Stryker is Assistant Commissioner of the Florida Department of Education and chair of the Articulation Coordinating Committee.*

As I said, we at this conference represent many areas of the state of Florida. This broad representation demonstrates the scope of the problems we face in allied health education.

The future of allied health education in Florida presents us with many problems and challenges. But we have many of the answers we will need already within our grasp. George Bernard Shaw once said: "All sorts of bodily diseases are produced by half-used minds." I want you to keep that quote in the back of your minds as you approach your work here today. This conference is an opportunity for us to use our whole minds – our full capacity – to address the pressing problems of allied health education.

The State University System, responding to testimony gathered in public hearings, has set a goal of increasing university enrollment in allied health programs. The commissioner's articulation committee, which I chair, adopted the goal of enhancing articulation of allied health education to help support the university system's goal. We know that in order to bring more students into the universities' allied health programs, we must reach out to community colleges and other institutions to attract those students.

That's why this task force was formed, and that's why you were invited here today to hear their findings and to help us develop plans and strategies for the future.

Here's a case that illustrates the kind of problems we are facing:

A woman – let's call her Nicole – graduates from a state school with an associate degree as a medical laboratory technician. Later she wants to get a bachelor's degree in medical technology from the same state system. She is shocked and disappointed to learn that none of her medical lab courses will transfer to her four-year degree program. She is told she will have to "start from scratch."

This is hardly the way to increase university enrollment in allied health programs, yet this sort of story is played out all the time. And it is our job here today to do something about that.

We need people like Nicole to stay in allied health careers – and we also need them to stay in Florida. Our older population makes health care a special concern to our state. If we don't respond now to help the university system meet its goal, the problem could get out of control.

I have a few statistics to show you what I mean:

Fact Number One:

- **According to the report "Workforce 2000" from the Department of Labor, Florida is the oldest state in the nation, and is rapidly getting older still. By the year 2000, 21% of Florida's residents will be over 65 years old.**

That means one in five residents in the state will be elderly. These older people are not just ciphers on a spread sheet – they are our neighbors, our friends and our parents. And they are going to need more health care and a wider range of health care services than a younger population would.

Fact Number Two:

- **According to a recent *Miami Herald* editorial, health care costs are rising at 12% per year – that's nearly three times the rate of consumer price increases.**

Health care costs are already the largest consumers of our gross national product, and this rate of increase will mean trouble for that growing number of older Floridians – our friends, neighbors, parents and eventually, ourselves. A shortage of allied health workers will only cause prices to increase faster, aggravating an already bad situation.

Fact Number Three:

- **The four fastest-growing job markets in the United States are here in Florida (Naples, Ft. Myers, Ft. Pierce and Orlando). In fact, 11 out of the top 25 fastest-growing job markets are in Florida.**

This rapid growth in the job market means increased competition for qualified workers. Even

as our population grows older – increasing our needs – the competition for workers may be decreasing our supply. And this cycle will fuel the rapid increase in health care costs.

As chair of the Articulation Coordinating Committee, I see a way for us to act now to avert this possible disaster. That is why we set up this task force, and that is why you were all invited here today.

This way I propose is not an easy way. It calls for change and cooperation. This kind of cooperation is never achieved without a struggle. Articulating hospital training, vocational education and community college and university coursework will stir up "turf wars," some elitism and some just plain old resistance to change.

But these problems can all be overcome. We must overcome them if we are to address the larger problem looming on the horizon of Florida's future.

The humorist Josh Billings once said: "When a man loses his health, then he first begins to take good care of it."

Unless we act now to encourage people to enter and remain in allied health careers here in Florida, we may find ourselves like the man in this little joke – taking care of something we've already lost.

Ladies and gentlemen, let's take care of our allied health education problems now – before we are sick, before we find ourselves with serious shortages and ruinous health care costs for our citizens – especially the elderly.

The wheels are already in motion. The task force has worked for months gathering information about these issues. Let's listen to them with all our attention, and bring our whole minds to the work before us here today. Together, I know we will find the answers.

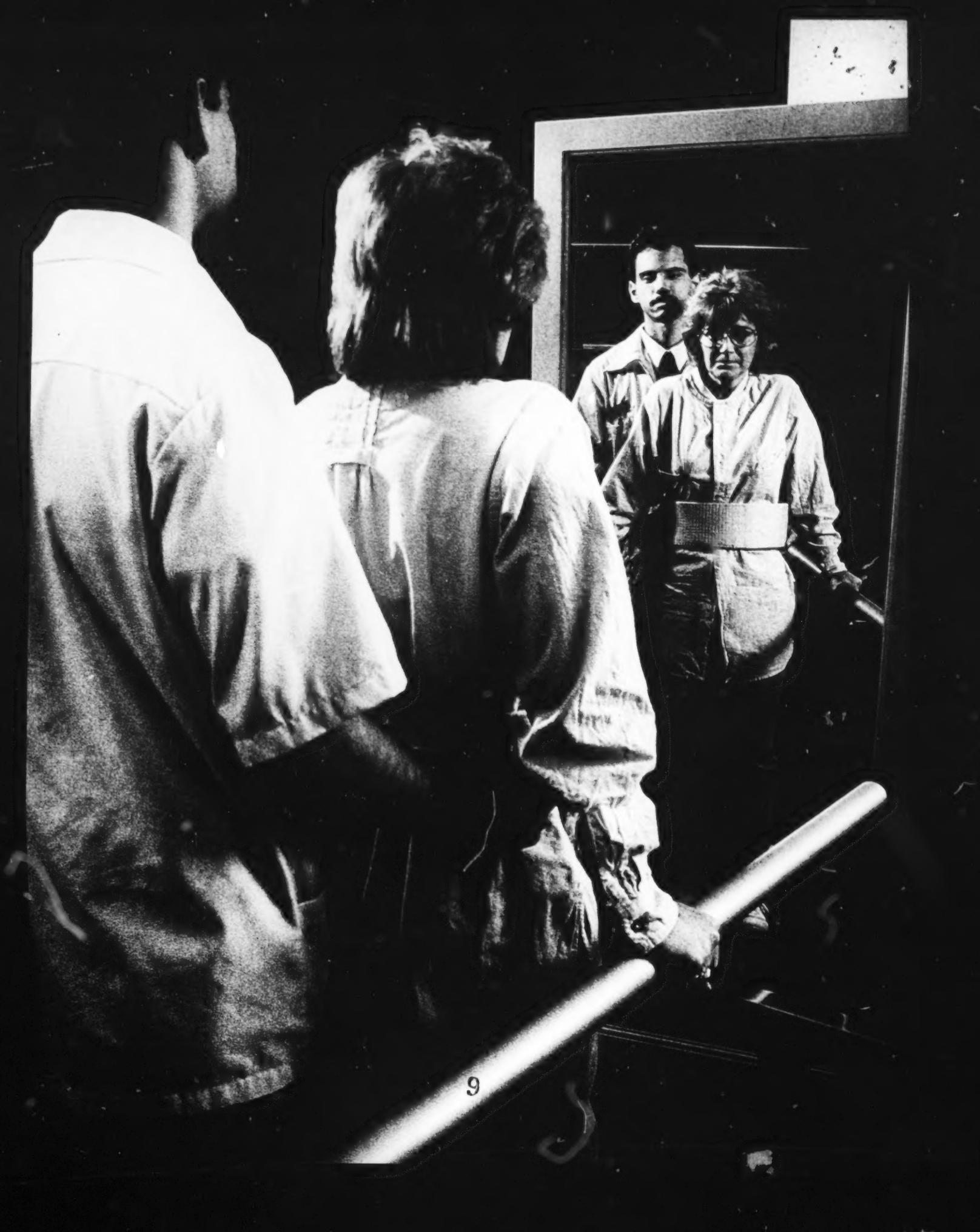
Thank you all for coming, and thank you for your attention.

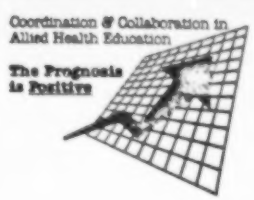
"THIS WAY I PROPOSE IS NOT AN EASY WAY. IT CALLS FOR CHANGE AND COOPERATION. THIS KIND OF COOPERATION IS NEVER ACHIEVED WITHOUT A STRUGGLE."

"A woman – let's call her Nicole – graduates from a state school with an associate degree as a medical laboratory technician. Later she wants to get a bachelor's degree in medical technology from the same state system. She is shocked and dismayed to learn that none of her medical lab courses will transfer to her four-year degree program. She is told she will have to 'start from scratch.'

This is hardly the way to increase enrollment in allied health programs. Yet this story is played out all the time."

Opposite: *Eleven of America's 25 fastest-growing job markets are in Florida. This rapid growth means increased competition for qualified workers – it's a seller's market for today's students. Unless we act now to encourage people to enter and remain in allied health careers here in Florida, we may find ourselves with a ruinous labor shortage in the field.*





Health Care Challenges and Choices: Alternate Pathways to the 21st Century:

"WHAT YOU LAUNCH HERE TODAY CAN HAVE A PROFOUND IMPACT."

Speech by Robert E. Kinsinger

When I first read the conference title, *Allied Health Education: Communication, Coordination and Collaboration*, the old French proverb immediately came to mind: "The more things change, the more they remain the same." In 1968 here in Florida, one of the cradles of the allied health movement, Darrel Mase, the founding dean of the University of Florida's College of Health Related Professions, presented a paper entitled "Whither Now" to the first annual meeting of the Association of Schools of Allied Health Professions. In that presentation twenty-one years ago, he stressed the importance of the "three c's for allied health education: communication, collaboration and cooperation." As Sam Goldwyn or Casey Stengel or one of those creators of deathless prose has said, "It's deja vu all over again."

> "DARREL'S THREE C'S, COMMUNICATION, COORDINATION AND COLLABORATION, STILL REPRESENT THE KEY TO EFFECTIVE ALLIED HEALTH EDUCATION."

Opposite: *Robert Kinsinger is a health education consultant and former Program Director of the W.K. Kellogg Foundation.*

The wisdom of the conveners of this conference is evident in the title selection. Darrel's three c's of two decades ago still represent the key to effective allied health education. We hope this will become clear as our discussions progress. My role today is to review for you some of the changing dynamics affecting health care delivery in order to better understand the context within which the communication, coordination and collaboration of allied health education must be planned and executed. In addition, it is my intention to offer a series of suggestions – more as thought stimulation than prescription – regarding some planning guidelines that might be helpful once we get our three c's in place.

Health Care Delivery Changes

The Changing Mix Between Acute and Long-Term Care

My first observation is that a major shift of emphasis and resources devoted to long-term care as opposed to acute care is underway and will accelerate. Chronic illnesses such as heart disease, diabetes, cancer, arthritis and multiple sclerosis are fast becoming the most prevalent forms of illness in the U.S. Granted, the initial approach to these illnesses calls for what our health care professionals provide most effectively – clinical treatments in traditional clinical settings. However, flaws of our system in responding to such illnesses are becoming increasingly apparent and will require major adjustments. They include a lack of comprehensive support for home health care, financial aid and counseling for the ill and their families.

To describe the shifts in the organization and resource flow of the health care system that will be required, let me quote from a recent analysis (1):

- A chronic illness **persists** over a lifetime
- When severe, it may have **many** phases
- Hospitals mainly care for the ill during the **acute** phases
- Periodic visits to clinics and doctors' offices are mainly for **stabilizing** the illness
- During **all** but the acute phases, it is the ill and their families who do the major work of managing the illness
- Therefore, the **home** should be at the very center of care; all other facilities and services should be oriented toward supplementing and facilitating the work done at home.

Consider for a moment what educational adjustments will be required when THE care center for long-term illness becomes the home. The ill and their families will do many aspects of the work. Practitioners will continue to do other aspects of the work, but the coordination of the illness work will become a major new service of the practitioner.

Consumer Activitism

Consumer activism and its resultant attention to alternative therapies, disease prevention, health promotion and self-care must be carefully monitored as we plan for new educational programs that adequately match service to needs. These trends emphasize the traditional role of health workers as teachers to the lay public. At the same time, they call for new approaches to preparing allied health workers as competent and accurate dispensers of information about disease prevention, health promotion and self-care.

The Growth of Health Maintenance Organizations

The anticipated rapid increase of Health Maintenance Organizations (HMOs) as the new organizational pattern for healthcare delivery has not fulfilled the original high expectations for this movement. Yet, the advent of these and other prepaid group practices presents an important setting for allied health teaching and practice.

When the federal government began providing funding in 1973 to establish HMOs with an eye to reducing health care costs, it was expected that

the nation would experience a rapid growth of these systems. By the end of 1987, however, only 12% of the U.S. population were enrolled in such programs. The economic stress being felt by these plans may be due largely to the rapidly shrinking length of stay in hospitals and tighter admissions controls that tend to eliminate the competitive edge of HMOs over fee-for-service practice. Two out of three HMOs failed to earn a profit in 1986. Nevertheless, allied health workers should learn to function within these unique health delivery systems. Similarly, HMOs must not be overlooked as particularly valuable settings for clinical training in ambulatory care.

Shrinking Opportunities for Clinical Training

The prospective quick-fix for the control of spiraling health costs, inaugurated by the federal government about a decade ago, has complicated substantially the allied health educator's job. Clinical experiences are becoming ever more difficult to arrange. Government policies have forced competition between health care agencies which has replaced cooperation. There thus has developed increasing duplication of costly services, technologies and even facilities as the newly created competition model focuses on the financial bottom line, and on carving out "market shares" from the competition's population.

The impact of the competition model on allied health education is two-fold: First, it results in shrinking clinical training opportunities. Secondly, there is a tendency to shift inappropriate tasks to less qualified technicians who have lower wage demands. This lean-and-mean approach does not permit hospitals to pass through educational costs. Given market driven priorities, institutions are adopting short-term survival strategies rather than giving adequate attention to long-term planning. This unfortunate institutional style complicates the essential process of arranging for the common goals of educational and health delivery systems to provide quality health care for all. There is a ray of hope for allied health education, however. The press of increasing health personnel shortages has reminded some administrators that clinical training taking place within their agencies is one of the best mechanisms for recruitment of new employees. Allied health educators should be quick to emphasize and use this.

Providing Health Care for Rural Areas

Health care in rural America is undergoing major change, and additional new arrangements will continue to be forced on small rural communities. In order to provide health care using traditional arrangements like hospitals, a critical mass of potential patients and financial support is required. Professional and social amenities sufficient to attract and hold health professionals are also needed to staff full service facilities. The shift to a competition model for health care agencies has influenced the demise of rural health care services. However, the general shrinkage of all elements of the necessary critical mass, together with improved transportation and communication, and the increasing complexity and cost of health care equipment have been the major contributors to the loss of more and more traditional health agencies in rural areas.

Several responses to the rural health care crisis are under study. Perhaps the most promising is a plan to operate rural hospitals as medical assistance facilities that will be equipped and staffed to provide only emergency and short-term care. These rural institutions would stabilize patients for safe transport to agencies offering the full range of traditional hospital services. Presumably, the financial and personnel requirements for such rural medical assistance facilities would be sufficiently less than the institutions they might replace to make it possible to sustain them in small population centers. An important implication is that such facilities, if properly operated, could function principally with allied health staffs. They would depend on nurse practitioners, advanced emergency medical technicians and others for leadership, much as the best mobile emergency units now serving large urban medical centers.

Responses to Health Care Delivery Changes

What then are some of the ways in which allied health planners could most profitably think about allied health education for the future in the context of these changes? Initially, it might be helpful to suggest a little different mental set for thinking about the firmly held notion that the major problem facing us is the shrinking cohort of health service personnel and how to quickly increase the numbers.

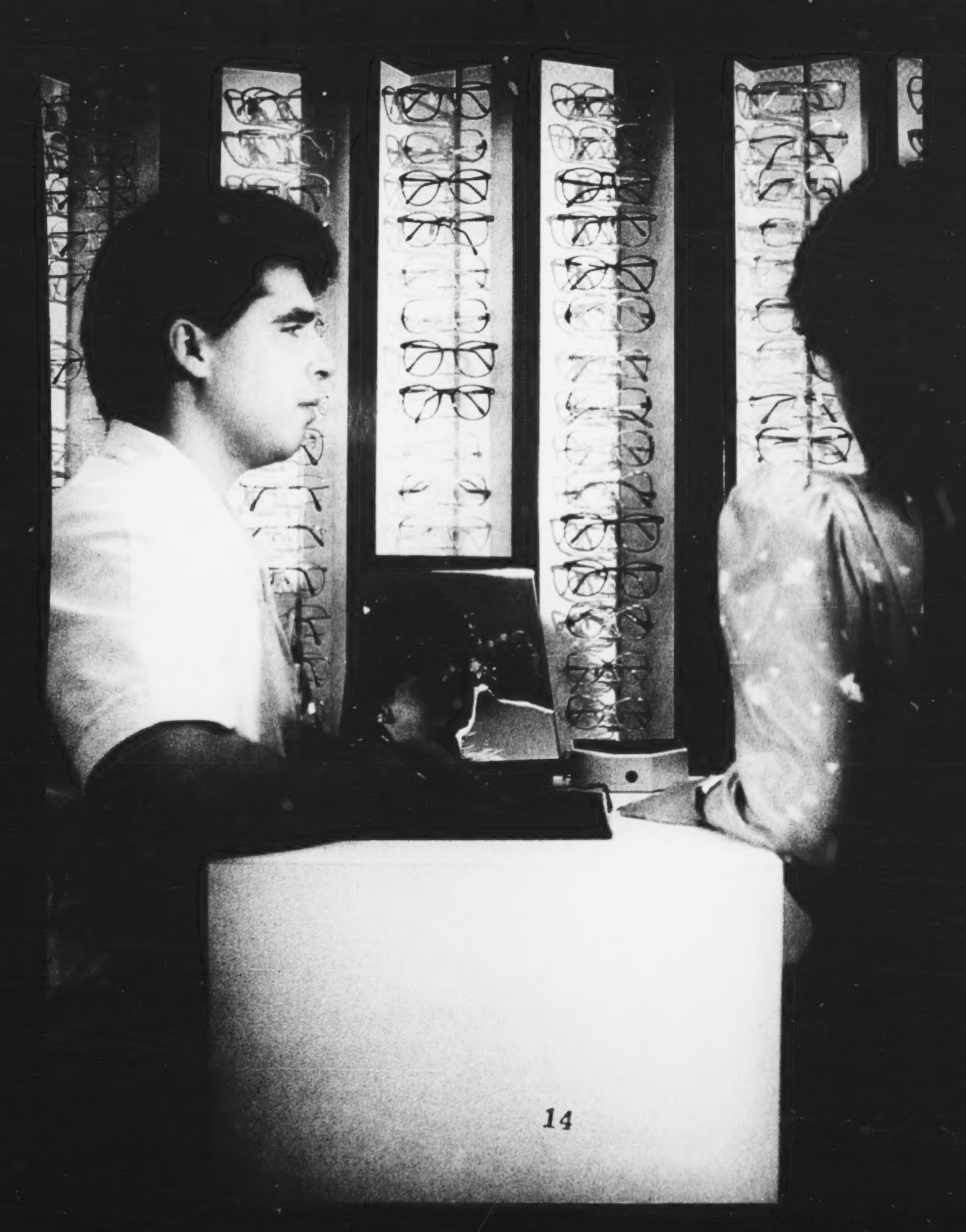
Simply stated, I suggest that the problem with which we are dealing is not strictly a shortage of health delivery personnel, but more precisely, a problem of PRODUCTIVITY. Given that slightly different spin to the issue, the ways in which communication, coordination and collaboration may be improved among various allied health educational programs and health service agencies may be seen in a somewhat different light.

One startling fact helps to build my case for changing the focus of the problem from "personnel shortage" to "diminished productivity." Hospital expenses have risen by 33% nationally in the last three years, even as the number of admissions has declined by 8%. This leads to my thesis that in such a labor intensive industry as health care, some of the increased costs must be due to the way in health delivery personnel are educated and utilized. Clearly, defensive medicine, rising overhead, unsatisfactory payment arrangements, expensive equipment and a myriad of other factors figure into the equation. Yet, to cite a simplistic example, the sight of a radiologic technician doing crossword puzzles while drawing a salary and waiting for patients requiring her circumscribed skills, or of a medical laboratory technician narrowly trained to do only specified tasks and therefore idle while work backs up in other departments, is not unknown. The fault and the solution relate to both how allied health workers are prepared and how their work assignments are planned and executed. These are productivity concerns not personnel shortages. They are the equal concern of both educators and service planners and managers (see reference 2).

Leaders in other service industries have recognized for some time that concentrating on a "worker shortage" tends to cloud the real problems and their solutions. All labor intensive serv-

"SIMPLY STATED, I SUGGEST THAT THE PROBLEM WITH WHICH WE ARE DEALING IS NOT STRICTLY A SHORTAGE OF HEALTH DELIVERY PERSONNEL, BUT MORE PRECISELY, A PROBLEM OF PRODUCTIVITY."

Opposite: *There is a major shift in emphasis and resources away from acute care and in the direction of long-term care. Flaws in our system of supporting care for long-term illnesses are becoming increasingly apparent and will require major adjustments.*



"MOST THOUGHTFUL PLANNERS KNOW THAT WE ARE ALREADY IN TROUBLE BECAUSE WE ARE DOING THINGS IN TRADITIONAL WAYS THAT DO NOT FIT CHANGING REQUIREMENTS FOR THE DELIVERY AND FINANCING OF HEALTH CARE."

Opposite: *Many hospitals learned long ago that they could no longer afford to maintain educational programs for allied health personnel. Instead, by working with local educational institutions, lobbying for funding, loaning equipment and employees to serve as teachers, health care agencies can help guarantee a better trained, more productive work force.*

ices, like the health care field, utilize a combination of machines and personnel which interact with each other to produce the desired service. Of course, the service requirements themselves are constantly changing as a result of social, scientific and technical changes. The interaction of machines, service needs and procedural changes, then, requires dynamic educational planning between service and educational agencies. Lasting gains come only when health care agencies finally confront the issue directly, investing in technology or restructuring jobs so that each worker can do substantially more. Moreover, the educator must be an equal partner in the efforts to drive down labor costs by constantly adapting education and training to best practice.

As Peter Drucker points out, the search for new utility requirements *organized abandonment of process and services.* Every process and service should be put on trial for its life every few years with this question: Would we now start this process or service in this way knowing what we know now? Organized abandonment applies equally to service and education.

Most thoughtful planners know that we are already in trouble because we are doing things in traditional ways that do not fit changing requirements for the delivery and financing of health care. A careful look at the demographic projections for the years ahead tells us there will not be enough service personnel to do things in the old way. Health care leaders have been wringing their hands in public for years over the constantly growing personnel problems, and providing authoritative facts and horror stories to dramatize their message. But change comes slowly and with great difficulty. We need courage to throw away old garments which have had their day and no longer fit the requirements of the new generations. However, that courage is often summoned only out of desperation. Desperation, I submit, is fast becoming our condition.

What meaning do these imperatives for change have for Florida's health care personnel problems? And, what implications are there for the work of Florida's Allied Health Articulation Project? First and foremost, it must be recognized that increasing productivity is an interdependent exercise. Improvement and innovation in health care delivery must be an interinstitutional effort. There is an ancient truism: You can't change just one thing. That concept is particularly appropriate in relation to health care delivery. Educational adjustments are triggered by new discoveries from medical research, new diagnostic and therapeutic equipment, demographic shifts and new health problems such as AIDS. A change in the education of health workers affects how they will function in the service setting. A change in the health delivery system calls for adjustments in education. Each new development affects the interrelated concerns of education, service and administration.

Health care agencies have a self-interest in increased cooperation with educational institutions. If they train their own employees, they double the cost of training because they have to pay salaries, too. Many hospitals learned long ago that they could no longer afford to maintain educational programs for allied health personnel. The growing complexity of health care calls for personnel preparation techniques far more complex than the apprenticeship type training formerly pursued by many hospitals. By virtue of continuous work with local education institutions including vocational schools, two-year colleges and universities – by lobbying state education departments, school boards and college trustees for funding – by donating up-to-date equipment – by loaning employees to serve as teachers and mentors – health care agencies can help guarantee a better trained, more productive workforce.

Now, what of the articulation between and among all levels of education for allied health personnel? This represents a particular emphasis of the Florida Allied Health Articulation Project. There is a long history of efforts to build career ladders spanning the educational spectrum offered by vocational schools, two-year colleges, four-year colleges and graduate schools. The literature is replete with plans for joint curriculum planning and articulation. Many a fine theoretical model has been laboriously prepared only to founder on turf issues and PERCEIVED insurmountable barriers of accreditation, certification, institutional degree requirements and licensure. In my observation, a great many of the failed efforts at interinstitutional planning have faltered more from a lack of collegiality and mutual respect among the planners than from practical problems of implementation. Further, the interinstitutional planning has sometimes lacked the enthusiastic and sustained support of the chief academic and executive officers of the institutions involved, often because they did not see these efforts at consortium building as high priorities. The absence of such support is usually deadly to any effort to alter the status quo.

Why should we anticipate success now after so many previous failures? I suggest it is a matter of shifting social priorities. As health care issues have become greater public concerns and news about mounting health costs and the growing difficulty in obtaining adequate health care has moved to the front pages, educational institutions are taking a new look at their role in confronting this national crisis. Hence, I predict that ways around those old barriers to interinstitutional planning may now be found. Building career ladders in the allied health fields presents a major challenge. But if turf issues diminish and unilateral educational planning gives way to better interinstitutional arrangements, most of the other problems can be surmounted. As the planning proceeds, it must be remembered that one key to increasing productivity is meshing the requirements of the work place with curriculum planning.

How can we benefit from the work of others who are addressing problems similar to those with which the Florida Allied Health Articulation Project is concerned? First, to help avoid frustrating journeys down dead-end roads, it may be valuable to remember that most lasting improvements to productivity usually come after trying and failing to overcome labor shortages with other tactics – tactics easier than modifying the skills and knowledge of the workers and changing the nature of the job. Although sometimes providing temporary relief, these impermanent tactics have included raising wages unrealistically, intensifying recruiting and importing immigrants.

Where are the success stories? One burgeoning movement for improving allied health personnel

productivity and restructuring the workload includes a series of pilot efforts to prepare and utilize workers known as multiskilled health practitioners. The working definition is, "a person who is crosstrained to provide more than one function, often in more than one discipline . . . The additional functions added to the original health care worker's job may be of a higher, lower or parallel level." The various approaches to this concept are well documented in recent publications of the National Multiskilled Health Practitioner Clearinghouse at the University of Alabama at Birmingham (3, 4). A variety of model educational programs in many different settings can be studied to learn how they dealt with the inevitable inertia to change, turf issues, certification and all of the other impediments to innovation. Again, any adaptation to a new setting must be a joint effort of service and education to fit the local circumstances (see reference 5).

Most service industries outside of the health care arena face the same personnel problems that health care is experiencing. A number of highly successful models are worthy of review as the Florida Allied Health Articulation Project moves to its next phase as a service-education consortium. In several instances, local industries have developed programs to motivate "high-risk" youth to meet the work force needs of local industry. I commend for your study the Peninsula Academies created when Hewlett-Packard and Lockheed Missile and Space joined forces with the Sequoia Union High School. Their joint goals were to increase high school retention and to help provide a technical work force for the Silicon Valley. Vocational programs are taught in high schools, with local companies providing equipment, mentors, on-site labs and summer jobs for students. One similar career academy since developed deals specifically with health care needs. Students enrolled in the Oakland Health Academy at Oakland Technical High School go to one of seven local hospitals to receive training on radiologic and other equipment the school could never afford. Last year, 98% of the students at the Oakland Health Academy received diplomas, and 86% went directly to college. That is the kind of feeder program that must be developed to deal with the productivity crises we face.

In order to tap an additional personnel pool, to increase retention and to improve productivity, plans for "step-in/step-out" educational programs for employed adults also need to be explored. Existing models such as the New York Regents College and Examinations (6) and Thomas A. Edison State University in New Jersey have had extensive experience in providing educational opportunities for those who cannot leave their jobs but want to advance in or change their employment. The Council for the Advancement of Experiential Learning (CAEL) provides a valuable resource for this type of planning, and certainly the ACE Adult Learner Assessment and Planning Guide (available from the American Council on Education) is an important tool.

To summarize my points let me suggest again that:

1. There is a changing mix between acute and long-term care that will affect how we prepare allied health personnel in the future.
2. Consumer activism will alter allied health and personnel preparation.
3. Health Maintenance Organizations must be considered as valuable allied health clinical training settings and may require curriculum adjustments relating to ambulatory care.
4. The competition model for health care delivery is shrinking opportunities for clinical training and alternatives must be sought.
5. A possible shift in the way rural health services are provided may have major implications for allied health education.
6. The problem generally viewed as a "worker shortage" may be more accurately a problem of "diminished productivity."
7. In any planning project, such as Florida's Allied Health Articulation Project, "you can't change just one thing."
8. Articulation between and among all levels of allied health education is paramount.
9. The preparation and utilization of multiskilled health practitioners may have great significance for increased productivity.
10. There are other service industries and innovative allied health education programs upon which to build. And, finally
11. Do not overlook the importance of continuing education for adults to provide an additional pool for recruitment, to increase retention and to improve productivity.

What you launch here today can have a profound impact. Good luck in your deliberations.

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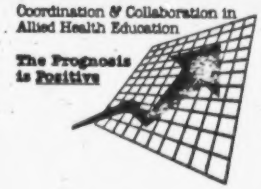
" DO NOT OVERLOOK THE IMPORTANCE OF CONTINUING EDUCATION FOR ADULTS TO PROVIDE AN ADDITIONAL POOL FOR RECRUITMENT, TO INCREASE RETENTION AND TO IMPROVE PRODUCTIVITY. "



Findings and Recommendations of the Allied Health Articulation Task Force:

THE QUESTION IS NOT "IF..." BUT "HOW."

Responding to calls for improved articulation in allied health education, the Allied Health Articulation Task Force has begun crafting a plan to achieve this goal. Two broad objectives were given to the Task Force as part of their original charge:

- Identify strategies to improve articulation among allied health education programs in vocational schools, community colleges, universities and other institutions within Florida; and
- Identify strategies to improve the database for educational planning in allied health.

"THE MOST IMPORTANT ALLIED HEALTH ARTICULATION CONCERN IS THE "JOINING TOGETHER" OF EDUCATIONAL PROGRAMS."

During the last four months, the Task Force spent time considering the full range of issues and choices that face Florida in addressing these objectives. They then targeted the specific issues that, in their view, should be placed at the top of the state's action agenda.

Knowing, however, that progress in enhancing allied health articulation will take concerted effort over considerable time, the Task Force also established the general framework upon which such continuing work will be based. Definitions were adopted, and philosophical guidelines were set. These will be described first. The presentation of Task Force findings and recommendations regarding specific allied health education issues, problems – and solutions – will follow. With help from conference participants, this set of issues and proposed solutions will be honed and refined to provide a focused set of marching orders for Florida's Allied Health Articulation Project, Phase II.

Definitions and Guidelines

What is Allied Health?

Allied health is a complex enterprise. Its complexity stems, in part, from the large number of diverse, specialized disciplines that make up the field. Many of these allied health specialties include multi-level occupations, and most adhere to their own distinct licensure, certification and educational accreditation standards. To compound the complexity, allied health is in a constant state of flux. The number of specialty fields has expanded as health care knowledge has advanced. The nature of the allied health professions has likewise shifted with changes in the structure of health care delivery. These changes are particularly pressing now.

It is not easy, then, to set a succinct definition for allied health. The Task Force utilized a process of exclusion. For project purposes, allied health was defined as all health care occupations that support the delivery of patient care, with the exception of nurses, physicians, dentists, optometrists, pharmacists and veterinarians. This captures a wide array of occupational areas which includes, among others, cardiovascular technology – clinical laboratory services – dental services – dietetics and nutrition – emergency medical services – health care administration – medical records – radiological services – physical therapy – occupational therapy – respiratory therapy – speech-hearing services – and vision care.

A simple listing of allied health occupations, like the above, highlights the segmented nature of the field. Rather than focusing upon such complexity, however, the Task Force chose throughout their work to highlight the **commonalities and interdependencies** among the allied health specialties. In their view, it is important to recognize the unique contribution of each specialty occupation. Yet, if we are to make progress in enhancing both allied health education and practice, it is equally as important that we seek to strengthen the **cohesiveness and "team-mindedness"** of the allied health specialty fields.

What is Articulation?

Generally defined, articulation means "joining together." The wide-ranging nature of allied health care thus presents an equally wide range of potential articulation concerns. Seen in a more positive light, it presents a wide range of opportunities to build dynamic new connections among both the various providers of allied health education, including vocational schools, community colleges and universities and the various providers of health care services.

In the view of the Task Force, the most important allied health articulation concern is the "joining together" of educational programs so that allied health professionals and students **may pursue continued education without undue loss of credit for prior learning.** Given this focus, the following definition was adopted:

- **Articulation is "a systematic coordination between an educational institution and other educational institutions and agencies designed to ensure the efficient and effective movement of students among those institutions and agencies, while guaranteeing the students' continuous advancement in learning" (Ernst, 1978).**

The primary intent of articulation is therefore to provide **flexible, alternative paths** for students who are entering allied health education programs from differing experiential and educational backgrounds. Both vertical and lateral mobility of students should be supported. Allied health professionals who choose to move into more advanced levels within specific disciplines should be granted credit for prior learning. The same is true for individuals who make career changes from one allied health field to another.

Still, while supporting educational and career mobility in allied health, the Task Force cautioned against making a value judgement that more education is necessarily better. To repeat, the overall goal is to increase what could be called **"mobility options"** for allied health professionals and students. Such a focus on articulation of learning must of course be balanced with assurances that the educational programs indeed prepare competent practitioners who are responsive to current health care needs. With this in mind, the project's working definition of articulation comes full circle to capture the notion of creating linkages not only across educational programs, but with health care delivery agencies as well.

Why is Articulation Important?

From the individual student's perspective, there is little doubt that articulation is important. The unnecessary duplication of educational experiences means an unnecessary loss of time, money and learning potential. From the broader public perspective, there are also forces that heighten the importance of improving articulation in allied health education. These include:

- **Pressures for Cost Effectiveness:** The costs of educational programs in allied health fields are high. Duplicative learning and duplicative coursework represent unnecessary expenses for the state and the health care industry.
- **Current and Potential Allied Health Manpower Shortages:** The attrition and turn-over rates are high in many allied health fields. Steps to facilitate greater educational and career mobility may be important strategies for improving the recruitment and retention of allied health practitioners.
- **Education as Life-Long Learning:** The view of vocational certificates and degrees as "terminal" or "non-transfer" no longer fits with the educational progression of many students. Allied health practitioners with vocational or hospital-based training often choose to obtain additional education at later points in their careers. Articulated educational programs are required to meet the needs of these "non-traditional" students.

Articulation in Allied Health Education: Not If, But How

The definitions and assumptions adopted by the Task Force document a firm belief in the value of educational and career mobility for the allied health workforce. Practical concerns, including manpower shortages, are likewise pressing the need to enhance such mobility. Within this framework, the question guiding the Florida Allied Health Articulation Project is not "should we", or "will we," work to improve articulation among the state's allied health education programs. Rather, the key question is, "how will we make articulation succeed?"

The Task Force recommends that efforts be focused on the following issues and activities. As presented in these written proceedings, the Task Force recommendations include revisions reflecting reactions from conference participants. More detailed discussion and background material for the recommendations will be available in the final report of Allied Health Articulation Project, Phase I.

ISSUE #1: THE PROBLEM

Efforts are needed to enhance the educational mobility of allied health practitioners who wish to advance into higher-level educational programs within their own specialty disciplines.

Articulation agreements must be developed to ensure that these students receive credit for prior learning, as assessed by student records, certification, licensure and job experience. It is particularly important that the students receive credit for any duplicative core technical courses.

ISSUE #1: STRATEGIES FOR ACTION

1. Undertake focused articulation development projects to design articulated curricula in the allied health disciplines of highest priority, such as medical laboratory technology, physical therapy and occupational therapy. These projects should be a central part of the Florida Allied Health Articulation Project, Phase II, and should be carried out through discipline-specific committees appointed under the Allied Health Articulation Task Force.
   - The committees should include practitioners and employers.
   - Curricula within the disciplines should be redesigned from the certificate through the baccalaureate levels. Competency-based education should be used as a negotiating framework to clarify overlapping content and to address such issues as appropriate program length.
   - Disciplines with the most promising potential for articulation should be identified and statewide articulation agreements developed.
2. Identify and distribute information regarding successful articulation models to faculty at the three educational levels to overcome the perception that "it can't be done."
3. Develop and support faculty networks within the allied health disciplines to improve communication among faculty across the vocational, community college and university levels. Faculty from relevant academic areas, such as science, should be included to improve communication across the basic and applied disciplines.

"THE INTENT OF ARTICULATION IS TO PROVIDE FLEXIBLE, ALTERNATIVE PATHS FOR STUDENTS ENTERING ALLIED HEALTH EDUCATION PROGRAMS FROM DIFFERING BACKGROUNDS."

Opposite: *The complexity of the allied health field stems, in part, from the large number of diverse, specialized disciplines it encompasses. Many specialties are multi-level, and most adhere to their own licensure, certification and educational accreditation standards.*

"FROM THE STUDENT'S PERSPECTIVE, THERE IS LITTLE DOUBT THAT ARTICULATION IS IMPORTANT. THE UNNECESSARY DUPLICATION OF EDUCATION MEANS LOSS OF TIME, MONEY AND LEARNING POTENTIAL."

Opposite: *A simple listing of allied health occupations highlights the segmented nature of the field. Rather than focusing on that complexity, the task force chose to emphasize the commonalities and interdependencies.*

ISSUE #2: THE PROBLEM

Efforts are needed to enhance the educational mobility of allied health students who wish to transfer across specialty areas.

These students include practitioners who are seeking to make career changes within the allied health field, as well as allied health students who wish to obtain cross-training in more than one specialty area.

ISSUE #2: STRATEGIES FOR ACTION

1. Develop a core curriculum for health programs which delineates the competencies essential for all health care occupations. This effort should be the highest priority task for the Allied Health Articulation Project, Phase II. It should be carried out through a committee appointed under the Allied Health Articulation Task Force, and should draw upon work already conducted in other states.
2. Conduct a study of the demand for and feasibility of establishing educational programs to cross-train health care personnel. The study should address the need for cross-trained personnel in rural health care settings, as highlighted in recent HRS and legislative proposals. However, it should also address broader issues of cross-training as these relate to the general "restructuring" of health care delivery.
3. Develop and implement a systematic process for assessing both formal and non-formal learning experiences of allied health students.

ISSUE #3: THE PROBLEM

Efforts are needed to promote systematic and sustained collaboration between health care providers and allied health education programs.

Such collaborative, mutually-beneficial ventures are increasingly important given the escalating costs of both health care delivery and education. Health care industries spend millions of dollars, for example, in addition to what is expended by education to recruit, train and retrain personnel.

ISSUE #3: STRATEGIES FOR ACTION

1. In Phase II of the Allied Health Articulation Project, identify and distribute information regarding effective models of collaboration between Florida educational institutions, accrediting and credentialing bodies and the health care industry.
   - This should include a review of collaborative activities initiated through the Florida Alliance of 100+ for Health Care Manpower, the Coalition of Industry, Education and Government for Health Related Issues and the newly enacted Nursing Education Challenge Grant Fund for Community Colleges.
   - Mechanisms to share the cost of providing orientation, inservice and licensure recertification for allied health personnel should be highlighted and promoted.
2. Encourage regional education programs from different levels within the same allied health field to share a single program advisory committee. By consolidating their industry advisory groups, the educational programs would create a more focused channel for involvement by local health care providers. Articulation across the educational programs would also benefit.

Improving the Florida Data Base for Educational Planning in Allied Health

Rational planning and policymaking for allied health care services, including allied health education, require reliable and valid data. Unfortunately, a lack of data to describe allied health manpower conditions has been a persistent problem both nationally and within Florida.

One objective of the Florida Allied Health Articulation Project, Phase I, was to design activities to improve the available manpower information. Based upon a review of all government agency data bases that collect and maintain data related to Florida's allied health workforce, the Task Force recommends that efforts be focused on the following issues and activities.

ISSUE #4: THE PROBLEM

Data related to allied health personnel within Florida are collected and maintained by approximately *twenty* different offices in *four* different state agencies.

There is also a wide array of non-governmental agencies that collect data related to allied health personnel. Yet:

- there is little shared knowledge about "who collects what."
- there are major gaps in the planning information that can be derived from the existing data bases.
- there is no focused state-level mechanism for coordinating or improving the existing data bases.

ISSUE #4: STRATEGIES FOR ACTION

1. The legislature should mandate and fund

an independent study to determine specific ways that the utility of existing state data bases related to allied health manpower can be improved. Study recommendations should include:

- Strategies for improving the adequacy of individual data sets.
- Strategies for improving coordination and linkages among data sets, including the designation of an appropriate location for a state clearinghouse or center for health-related data.

Resources should then be provided to implement the recommendations.

2. While efforts are being made to improve state-level data systems, efforts should also be made to synthesize all the data that does exist on allied health manpower conditions in Florida. There are significant gaps in the available data, and accessibility of data is a problem. Still, useful profiles of job market conditions could be developed for most of the allied health fields by tapping into data currently available from agencies and organizations across the state. The task of compiling existing data into profiles for each of the allied health fields should be undertaken by the HRS Office of Comprehensive Health Planning in close coordination with the Allied Health Articulation Project, Phase II.

ISSUE #5: THE PROBLEM

In addition to improvements in the state-level data base related to allied health manpower, there is a need to improve conduits for exchanging such information on the local level.

Local level communication and collaboration among educational programs and health care employers may provide one of the most promising approaches to modulating supply and demand for allied health personnel. Such communication is critical if educators are to base their program plans and resource allocations on an accurate understanding of the "mix" of different allied health personnel needed within their regions.

ISSUE #5: STRATEGIES FOR ACTION

Encourage regional education programs from different levels within the same allied health field to share a single program advisory committee. This committee should have broad-based health care industry representation. (see Issue #3.)

ISSUE #6: THE PROBLEM

The need to improve information bases related to allied health personnel extends beyond the lack of adequate data for policy making and program planning purposes.

The allied health field is complex and not well understood by the general public. In this regard, there is a particular need to improve the information that is available to support student counseling and recruitment activities.

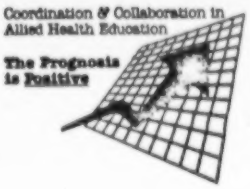
ISSUE #6: STRATEGIES FOR ACTION

Focused efforts to strengthen student guidance materials and services should be undertaken in Phase II of the Allied Health Articulation Project. These efforts should include:

- An assessment of relevant career education materials and services provided through the DOE Center for Career Development, as well as the SOLAR and SASS advisement systems.
- Training for guidance counselors regarding educational and career opportunities in allied health care.
- Assistance in compiling and distributing the *Florida Health Care Directory*, a forthcoming publication of the Alliance of 100+ for Healthcare Manpower.

"THE QUESTION GUIDING THE FLORIDA ALLIED HEALTH ARTICULATION PROJECT IS NOT "SHOULD WE," OR "WILL WE," RATHER, THE KEY QUESTION IS "HOW WILL WE MAKE ARTICULATION SUCCEED?"

Opposite: *When all is said and done, there is little doubt as to the necessity of making articulation work. Duplicative learning and duplicative coursework represent unnecessary expenses and unnecessary obstacles to mobility within the field.*



Allied Health Education: Communication, Coordination and Collaboration – Commentary and Synthesis:

"I WILL BE WATCHING FLORIDA'S LEADERSHIP IN THIS AREA WITH GREAT FASCINATION."

Speech by Michael L. Millman, Ph.D.

My charge here today is to sum up what I have heard during the proceedings and to place the discussions in some larger perspective. This I shall attempt to do based on the experience of having directed the Institute of Medicine's (IOM) recent report for the U.S. Congress, *Allied Health Services: Avoiding Crises.*

> "I HAVE BEEN EXCITED BY THE COMPOSITION OF THIS GROUP AND ITS DISCUSSION TODAY."

Michael Millman was Director of the Committee to Study the Role of Allied Health Personnel at the Institute of Medicine, Washington, D.C.

Opposite: *One problem in forecasting need in various fields is determining how to assess the future effect of medical and labor market developments. How these forces operate on the allied health field will greatly affect demand within various occupations.*

This assignment is a pleasant change of pace for me. Usually, I address groups about our study, its content and major recommendations. In one respect, however, the task today is very similar to what the Institute of Medicine staff does for a living. Most of our work is accomplished through distinguished committees. The staff listen to these experts discuss the issues, review the data we amass for them and help them formulate recommendations. The challenge is to make sense out of many hours of discussion, shape it into an understandable, logical report and present it back to the committee to see that the words truly reflect their intent. That is what I hope to do here in the next few minutes. However, I will also liberally sprinkle in my own thoughts for extra measure. Hopefully, they will be of some practical use as you contemplate next steps in this laudatory process you have undertaken.

Ostensibly this group was convened to discuss an important public policy issue: How well are society's needs being met by the process of getting the right people into health care jobs with the right amount of education and with a reasonable degree of educational efficiency? However, there is a human side to this broad issue. Namely, we are dealing with people's careers – how their careers progress over time and how they will spend a good chunk of their lives. This human side is central to articulation, and should be kept in mind throughout your efforts.

In the IOM study, the Committee concluded its recommendations with the following comment that is relevant to the group gathered together here: "None of the committee's recommendations is self-implementing. Each requires a principal party to convince others to join in their efforts or to accede to alterations in traditional ways of operating, whether in educating students, delivering services or supporting professional interests." I have been excited by the composition of this group and its discussion today – along with other things happening in Florida, such as the Alliance of One-Hundred Plus for Health Care Manpower. I see Florida putting into action many of the ideas that undergird the IOM report.

With this preface, let me now talk about the two main topics of the meeting – articulation and improved data.

Articulation – allowing allied health professionals and students to pursue continued education without loss of credit for prior learning – encountered little opposition at the conference. Convincing others within the profession and the educational establishment may not be so easy.

Articulation

I expected to see more evidence in the discussions of what allied health dean Betty King refers to as the "insidious barrier" of professional biases and academic snobbery, which she claims creates an undiscussable tension standing in the way of progress on articulation issues. I don't know whether the tension did not surface because we are all believers gathered to muster the courage to take on the infidels, or that it is going to be a piece of cake convincing the recalcitrant few remaining in Florida. I suspect it's more of the former. I think the issue has to be faced directly.

The IOM study had a strong recommendation for states to make articulation happen. However, it will be important in my view to understand where the professional groups are coming from on this issue and confront their (sometimes justifiable) fears and concerns directly.

I have heard a number of good suggestions about looking at models from other states. If you do this, I suggest that a number of analytic dimensions be taken into account as you assess the models. Here are some questions that come immediately to my mind:

- What is the political and bureaucratic context or culture in which the policies operate in particular higher education communities?
- What are your criteria for successful models?
- Who makes it happen?
- Are the processes that lead to success the results of formal or informal interactions?
- Who initiates action?

In addition to suggestions about exploring existing models, I overheard a number of good ideas surfacing in the group discussions that can be categorized loosely as targets for communication to improve articulation:

Professional Associations

There is a need for better communication with state and national professional associations. Sometimes articulation is hampered by lack of clarity over the essentials, the objectives of the leadership or the concerns and fears of the membership. Are there ways of enlisting the help of professional societies at the state or local level, if not the national organization?

It was suggested that if community college and university faculty were placed in the position of having to jointly design a curriculum, they would better understand where each was coming from.

High School Counselors

There is a great deal of dissatisfaction over the information high school counselors pass on to their students about careers and pre-requisites. Yet, there was an appreciation of how difficult their jobs are. Would an investment in interactive computer systems be an effective way of bridging the communication gap?

Employers

Hospitals and other health care employers are coming to the painful recognition that the labor market is not going to supply them with the steady flow of personnel that they counted upon in earlier days. The innovative example of the hospital-financed college recruiter who also deals with problems of employee retention was presented. We have only begun to explore the potential of employers as a major player in the shape education takes in the future. How can they be used as a major source of demand for articulation or as a way of retaining and upgrading people who are already employed in the health care industry? Furthermore, what potential do hospitals have in facilitating communication among education institutions?

Faculty

In discussing whether it would make sense to have a core curriculum for allied health to improve student and institutional flexibility and to surmount the problems of the large diversity among college programs, it was suggested that if community college and university faculty were placed in the position of having to jointly design a curriculum from the bottom up they would better understand where each was coming from. I think the point here is that unless opportunities are created forcing faculties to speak to one another, productive communication is less likely to take place on its own.

Data

A major theme for this meeting in addition to educational mobility was the need for better statewide data. In conducting the IOM study, we learned a great deal about what data exists to both describe allied health fields and to support policy recommendations. Beyond our recommendations for better collaboration among national actors to improve the data base, the body of the report itself attempts to provide a framework for state and local planners to begin thinking about ways to monitor the changing balance between supply and demand. This framework emphasizes the importance of understanding the driving forces behind demand and supply both at the national and local level. These forces include such things as demography, disease changes, technology, the shifting structure of the health care delivery system and policy changes. How these forces are operating broadly in health care and their differential effect on specific occupations is a key to improved projections about the future adequacy of the labor supply.

There are a number of specific points on the topic of data I would like to highlight from the perspective of the IOM study that I think you ought to keep in mind.

"WE HAVE ONLY BEGUN TO EXPLORE THE POTENTIAL OF EMPLOYERS AS A MAJOR PLAYER IN THE SHAPE EDUCATION TAKES IN THE FUTURE."

Opposite: *As they recognize that a greater and greater part of their future labor force will come from allied health programs, hospitals can become a driving force for articulation.*

CAUTION
STAINS & DYES CONTAIN ALCOHOL
KEEP AWAY FROM OPEN FLAME

"UNLESS OPPORTUNITIES ARE CREATED FORCING FACULTIES TO SPEAK TO ONE ANOTHER, PRODUCTIVE COMMUNICATION IS LESS LIKELY TO TAKE PLACE ON ITS OWN."

A major theme running through the conference was the need for better statewide data. A great deal of it already exists, in one format or another. The problem is getting it into a readily accessible form.

Tie Data to Policy Questions.

There are no magic data bases that will answer every decision-maker's needs. The standard approach is to lay out all the data that would be nice to know. Unfortunately, this often leads to expensive systems that fall of their own weight. What are the important questions that higher education officials and healthcare institutions must ask in order to plan for tomorrow and use available human and dollar resources well? How accurate does the information have to be to answer the question?

Use Existing Data Bases Where Possible.

It is better to invest in ways of interpreting data from ongoing systems or produce the evidence to modify those systems than starting from scratch. The occupational employment survey conducted by state labor departments is an important case in point. Efforts should be devoted to strategic use of data quality and validation studies and ways of adapting national data for state use.

The Right Assumptions Are As Important As Data.

Knowing that the Health Care Financing Administration changed its regulations in the early 1980s that require rehab patients receive 3 hours of therapy services per day was as important for predicting the current demand for occupational and physical therapists than anything else. It is critical for state planners to be able to understand local labor market dynamics in order to do appropriate planning.

There Are A Lot Of Wasted Efforts.

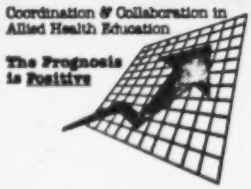
Education institutions devote countless hours to preparing for accreditation visits. This effort is often lost since no one centralizes the information amassed during self-study exercises. Another example are alumni surveys which institutions often conduct on their own. A standardized instrument and a central repository would make sense to me.

Employers Ought to be Brought Into the Process.

Employers have a stake in good data on the pipeline of future workers. The higher education community should take advantage of the growing fears about shortage and the need to rethink who will be available to do what jobs with what kinds of education.

I hope these comments are useful as you take the next steps on a very long but exciting journey. I will be watching Florida's leadership in this area with great fascination. Thank you for letting me participate in this enterprise.

Opposite: *There is a human side to the broad issue of allied health education. Namely, we are dealing with people's careers – how they will spend a good chunk of their lives.*



Conclusion:

WHAT COMES NEXT:

The Next Steps Toward Florida's Allied Health Articulation Project, Phase II

The work accomplished in Phase I of the Florida Allied Health Articulation Project is just a beginning. Efforts to build a truly articulated system of allied health education and service will expand. These conference proceedings set forth the broad framework upon which such efforts will be founded. Together, members of the Allied Health Articulation Task Force and conference participants have constructed the specific agenda for action.

Continued communication, coordination and collaboration will be the keys to our success in enhancing the articulation of allied health education within Florida. As such, they will serve as the guiding force for activities of the Allied Health Articulation Project, Phase II. During the upcoming year, the Allied Health Articulation Task Force, as an arm of the Commissioner of Education's Articulation Coordinating Committee, will provide leadership in carrying out activities targeted for high-priority attention. Activities recommended by the Task Force include:

- the identification of a core curriculum for Florida health care education
- the development of model articulated curricula in several specific allied health disciplines
- the exploration of approaches to preparing multicompetent health care personnel
- collaboration across agencies and data bases to develop profiles of Florida allied health manpower conditions
- an independent study to determine specific strategies for improving the state's allied health data bases
- the strengthening of student guidance materials and services in the allied health fields

The Task Force will begin the Phase II activities in Fall, 1989.

Of course, the real work of accomplishing these tasks – and the credit for ultimate success – will rest with allied health educators and health care professionals from across the state. We encourage you, therefore, to seek to maintain the momentum gained at the conference. Build bridges that span educational levels and other traditional boundaries in allied health. Enter into creative new partnerships with Florida health care providers.

We acknowledge that these endeavors will not be easy. The dialogues will be spirited and undoubtedly emotional. Nevertheless, a shared commitment to overcoming the challenges involved in building an articulated system of allied health education will yield important benefits. For students and professionals in the field, it will mean more flexible educational and career opportunities. For Florida as a whole, it will bring greater assurance that the education we provide for our allied health workforce is cost effective, and that it remains closely matched to the state's health care needs.

"OF COURSE, THE REAL WORK OF ACCOMPLISHING THESE TASKS – AND THE CREDIT FOR ULTIMATE SUCCESS – WILL REST WITH ALLIED HEALTH EDUCATORS AND HEALTH CARE PROFESSIONALS FROM ACROSS THE STATE."

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